Beyond Hierarchy?

An assessment of the Early Phase of Implementation of the Beyond Hierarchy Initiative at North Staffordshire NHS Trust

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Executive Summary

Introduction

This report provides an assessment of the early stages of implementation of the Beyond Hierarchy project at North Staffordshire Hospital NHS Trust. The objective of Beyond Hierarchy is: "Its aim is to empower every nurse and midwife to make an effective contribution to the organisation of North Staffordshire Hospital NHS Trust" (North Staffs, 1997). The Beyond Hierarchy approach utilises elements of shared governance in involving nursing and midwifery staff in decision making.

Beyond Hierarchy represents an attempt by North Staffordshire NHS Trust to more fully involve clinical staff in decision making at the Trust. As such, it reflects a trend towards supporting staff involvement and partnership which has been highlighted in recent government policy in the NHS White Paper (1997) [1].

In January 1998 a research team co-ordinated by Queen Margaret College were commissioned to undertake an assessment of progress in the early phases of the introduction of the Beyond Hierarchy project. The research was funded by the Department of Health, and had as its main objective "to undertake a descriptive case study assessment and demographic/attitude baseline survey of the initial phase of introducing the Beyond Hierarchy initiative at North Staffordshire Hospital NHS Trust". The study used literature review, focus group discussions, interviews with key personnel and a baseline questionnaire survey of 500 nurses and midwives employed in the Trust. The study was conducted in the period from January to July 1998.

This report presents both an assessment of the early phases of the introduction of Beyond Hierarchy, and a series of baseline indicators which can be used in the future to check on change and progress of implementation.

The Survey

The main focus of the case study assessment was the questionnaire survey of 500 nurses and midwives at the Trust. The response rate was 60%. The sample was structured to include nurses and midwives from all locations within the multi-site trust, and to be representative of all clinical grades. The objectives of the survey were to provide baseline demographics and attitudinal measures which could be referred to in any subsequent evaluation of Beyond Hierarchy, and to give an indication of the experiences and opinions of staff in relation to the early phase of Beyond Hierarchy.

The key questions examined in the survey were:

- what are the current attitudes and experiences of the nurses and midwives in relation to their careers, work environment and professional activities?
- what is their level of awareness of Beyond Hierarchy?
- what is their extent of participation in Beyond Hierarchy?
- what are their perceived barriers and incentives to participation in Beyond Hierarchy?
- what are their perceived attractions and limitations of Beyond Hierarchy?

Two subgroups were covered in the survey;

- an "active group" – which covers those who have participated in Beyond Hierarchy groups (79 responses) and
- a "non-active" group - those who have not been actively involved (220 responses).

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1. The Department of Health (1997) *The New NHS: Modern, Dependable.* London: The Stationery Office

The active group was selected on the basis of their current or recent involvement whilst the non active group was a random sample of qualified nursing and midwifery staff at the Trust.

There was little difference in the demographic characteristics of the two groups, in terms of gender, age, or length of time working in the trust or in current post. The North Staffs nursing and midwifery workforce is relatively stable, with low turnover and a high average length of service. The only difference of note was that the "non active" group has a more polarised age profile, with proportionately more older and younger nurses and midwives than the "active" group.

Table 1
Type of Employment

		Active (%)	Non-Active (%)
Contract:	Permanent	96	97
	Fixed Term	4	1
	Bank/Other	-	2
	Full Time	89	65
	Part Time	11	36
Shift Work?	Yes	61	79
	No	39	21
Baseline (n=)		**79**	**220**

An examination of type of employment (Table 1) reveals that active respondents were more likely to work full time, and less likely to work shifts than non active respondents. This reflects the difference between the two groups in terms of job title and grade, but also highlights a challenge to the steering group and project groups increase the active participation of part time staff, and lower grade nurses and midwives in Beyond Hierarchy.

Table 2
What issues would you most like staff nurses and midwives to have more involvement in?

Active Group	Non-active Group
1. Addition of activities to nurses / midwives roles	1. Staffing levels
2. Access to training	2. Purchase of new equipment
3. = Clinical Role of Nurses/Midwives = Staffing levels	3. Grade mix on the wards

The respondents were asked to indicate which items they would most like staff nurses and midwives to be more involved in. This response (Table 2) gives an indication of the differences between the two groups. The active group were more likely to highlight what could be termed 'professional' issues, linked to role and training, whilst the non active group were more likely to highlight work related issues - equipment purchase and staffing levels/grade mix. Staffing levels were highlighted by both groups.

Communications and Beyond Hierarchy

Respondents were asked to rate the usefulness of various media, in terms of telling them what is happening in the Trust. The results are presented in Table 3.

Table 3
How useful do you find each of the following for telling you about what is happening in the Trust?

	Very useful %		A bit useful %		Not at all useful %	
	A	**NA**	**A**	**NA**	**A**	**NA**
Senior nurse managers	36	21	43	54	20	26
Ward manager	60	60	36	35	4	5
Colleagues	55	63	43	33	3	4
Trust wide news (TWN)/e-mail	35	27	51	48	14	25
Connections	26	21	57	55	16	23
Cascade briefings	27	13	60	51	14	36
Beyond Hierarchy Newsletter	37	23	58	62	5	16
Memos	36	40	51	54	14	5

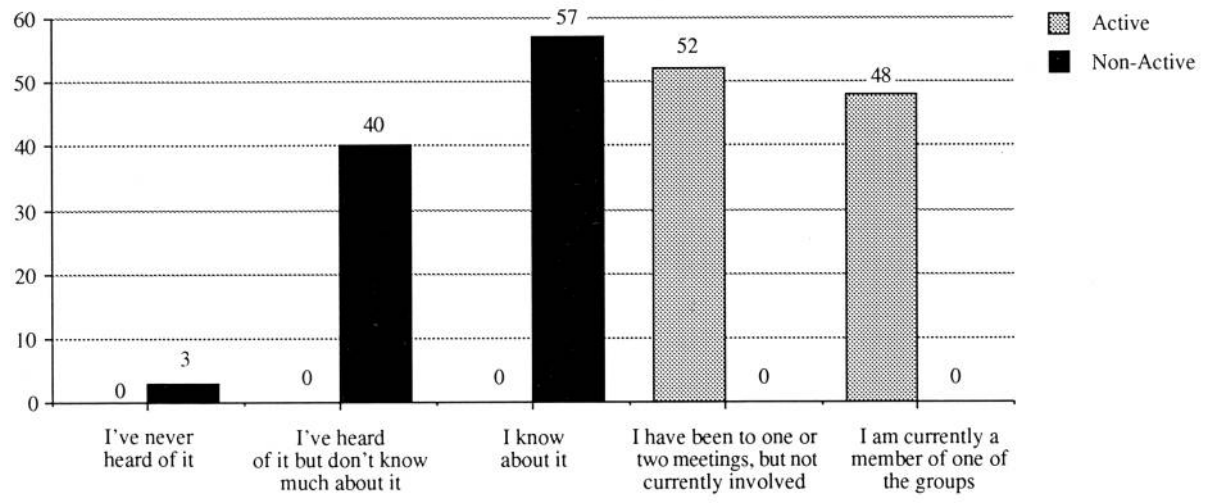
A = Active Staff (n = 79) **NA** = Non Active Staff (n = 220)

Both groups rated ward managers and colleagues as the most useful sources of information. Active respondents were more likely to give a positive response, but overall, the pattern of responses from both groups was generally positive about the different methods of communication being used in the Trust. The Beyond Hierarchy Newsletter, which focuses specifically on Beyond Hierarchy issues rather than being a broad based newsletter, was rated "useful" or "very useful" by 95 per cent of active respondents and 84 per cent of non active respondents.

Participation in Beyond Hierarchy

The responses to the survey are shown from "active" and "non active" groups in relation to their level of involvement with Beyond Hierarchy. The overall pattern of involvement in Beyond Hierarchy at the time of the survey is shown in Figure 1.

Figure 1
Level of Participation in Beyond Hierarchy. (% response for active and non-active groups)



Membership of the groups is voluntary, and therefore fluid. At the time of the survey, approximately half of the "active" group reported that they were actually members of one or more groups. In the non active group, only a small minority (3%) reported they had not heard of Beyond Hierarchy, whilst 57 per cent indicated that they knew about it. The overall response suggests that the communication strategy for Beyond Hierarchy has been broadly successful. The Beyond Hierarchy newsletter and ward manager briefings were most commonly reported as the main source of information on Beyond Hierarchy.

The majority of respondents indicated that they either knew about Beyond Hierarchy, or had become directly involved in the project. It is apparent that currently only a minority of staff are actively involved in Beyond Hierarchy. The main challenges for the project teams are to encourage more of the non active respondents to become involved, and to maintain the involvement of those in the active group.

What can be done to encourage more staff nurses and midwives to become actively involved in Beyond Hierarchy? The most common responses to the question of why they were not currently involved in Beyond Hierarchy are shown in Table 4.

Table 4
If you have not been involved in any of the groups, please describe why not (most common responses)

1. **Don't have time**	- too many other commitments - too busy with other projects
2. **Lack of Advertising/Information**	
3. **Not Invited**	

These responses highlight two issues which were also reported in the focus groups. Some nurses and midwives indicated they would wish to be more fully involved, but find it difficult to find the time because of their other work and domestic commitments. The second main barrier to participation relates to a lack of detailed information. The positive aspect of this response for the project teams is that there does not appear to be an inherent disregard for Beyond Hierarchy amongst non-active nurses and midwives. Only four respondents, out of 220 'non active' staff, indicated that they were not interested in Beyond Hierarchy. The reported barriers are work related and communication based, rather than psychological, and therefore are more open to direct intervention.

Respondents were also asked to indicate what would most help them to get more involved in Beyond Hierarchy (Table 5).

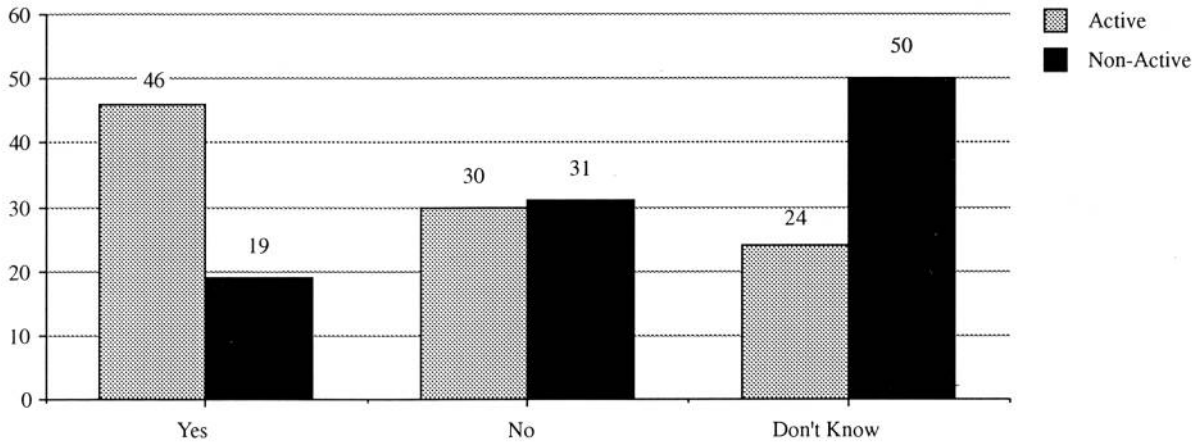
Table 5
What would most help you to get more involved? (non active group - most common responses)

1. **More time off from ward**
2. **More information**

Two responses were commonly reported. Unsurprisingly, they are the mirror image of responses to the previous question, and highlight the perception that allotted time away from ward work, and more information would enable and encourage more staff nurses and midwives to become involved in Beyond Hierarchy. This highlights the scope for intervention.

The future intentions of respondents in relation to Beyond Hierarchy was examined when respondents were asked to indicate if they wished to become more involved in the project (Figure 2).

Figure 2
Would you like to become more involved in Beyond Hierarchy ? (% response)



The response indicates that about a third of active members and the same proportion of non active members do not intend to become more fully involved, and that nearly half (46%) of active members indicate that they would like to be more involved. The main challenge will be to stimulate participation amongst the large group (50%) of non active members who are currently undecided. Given the results reported above, this challenge will be best met by further detailed communications, briefings by ward managers, and the provision of support to staff to enable them to balance other work commitments with participation in Beyond Hierarchy.

A suggestion that came out of the focus groups, was that involvement in Beyond Hierarchy could be increased by offering staff a wider range of methods for taking part in it (eg. through more effective two-way communication with the groups by e-mail). At present, involvement primarily takes the form of attending meetings, which as the survey shows, can be difficult for some staff.

Views about Beyond Hierarchy

The pattern of responses in relation to nurses' and midwives' views of Beyond Hierarchy is unsurprising (Table 6). "Active" respondents were more likely to 'agree' or 'strongly agree' with positive statements about Beyond Hierarchy.

Table 6
Views about Beyond Hierarchy

	Agree %		Neither %		Disagree %	
	A	**NA**	**A**	**NA**	**A**	**NA**
BH is an excellent idea	85	57	11	39	4	4
I am satisfied with the amount of information I have had about BH	74	44	10	23	15	32
BH is a good idea in principle but I don't think it will change anything	29	38	27	42	44	20
BH is well supported by managers	54	40	28	51	18	9
BH focuses on the topics that really matter to nurses/midwives	69	52	17	41	14	8
I have too many other commitments to get involved with BH	39	62	27	27	34	11
BH gives lower grade nurses/midwives a chance to have a say	78	56	10	33	11	11
BH is run by senior grades	31	26	10	40	59	35
BH is just a hype to make the Trust look good	13	29	27	47	60	24
BH will give real power to nurses/midwives	42	20	42	52	16	28
BH is a waste of time	8	8	23	44	69	48

A = Active Staff (n=79) **NA** = Non Active Staff (n=220)

However, what is particularly important about the response of the majority of non-participants is that even in this group there appears to be a generally positive (or at worst, neutral) view of Beyond Hierarchy. Over half of non active respondents agreed that Beyond Hierarchy was an excellent idea and that it gave lower grade nurses and midwives a "chance to have a say".

The high ratio of "neither" responses on some items suggests that many respondents remain to be persuaded about some of the claimed potential benefits of Beyond Hierarchy, and are not yet sure if it is 'hype' or will give real power to nurses and midwives. Generally, however, there was a positive pattern of responses, with few non active respondents indicating that they believed Beyond Hierarchy was unfocused, or a waste of time.

The findings of this assessment of the early phase of implementation are broadly neutral or positive. The current attitudinal profile of nurses and midwives at the Trust shows that the majority of staff are satisfied with most aspects of their work; the areas of most concern are workloads and the extent to which they feel they are valued. Lower grade staff were generally less likely to report satisfaction than staff in higher grade positions.

It is too early in the implementation of Beyond Hierarchy to provide a full evaluation; but the results so far point to the broad direction of implementation being satisfactory. There is a continued need to co-ordinate the activities of the groups, to support effective communications and to ensure that the commitment of line and senior management is maintained.

Chapter 1: Introduction

This report provides an assessment of the early stages of implementation of the Beyond Hierarchy project at North Staffordshire Hospital NHS Trust. The objective of Beyond Hierarchy is: "Its aim is to empower every nurse and midwife to make an effective contribution to the organisation of North Staffordshire Hospital NHS Trust" (North Staffs, 1997). The Beyond Hierarchy approach utilises elements of shared governance in involving nursing and midwifery staff in decision making. North Staffordshire Hospital NHS Trust is one of the first Trusts in the NHS to move forward from theory to practice in implementing these methods to support staff empowerment.

The Beyond Hierarchy project was established as a result of a workshop for 'G' grade sisters and charge nurses held in March 1997. This workshop identified hierarchy as one of the issues which had to be addressed if all nurses and midwives in the Trust were to have the opportunity to be actively involved in agreeing a strategy for nursing and midwifery. A Steering Group was established, which organised an 'Open Space' Day in June 1997. At this event over 40 topics were initially identified as being of importance to nurses and midwives in the Trust; these were condensed into four themes:-

- communication
- clinical supervision
- practice development
- professional identity

Nurses and midwives could volunteer to participate in one or more of the four theme project groups; overall activity was co-ordinated by the Steering Group. Two of the project groups have since merged.

The Beyond Hierarchy approach, which shares some central characteristics with that of shared governance, represents an attempt by North Staffordshire NHS Trust to more fully involve clinical staff in decision making at the Trust. As such, it reflects a trend towards supporting staff involvement and partnership which has been highlighted in recent government policy in the NHS White Paper (1997) [1].

In January 1998 a research team co-ordinated by Queen Margaret College were commissioned to undertake an assessment of progress in the early phases of the introduction of the Beyond Hierarchy project. The research was funded by the Department of Health, and had as its main objective "to undertake a descriptive case study assessment and demographic/attitude baseline survey of the initial phase of introducing the Beyond Hierarchy initiative at North Staffordshire Hospital NHS Trust". The study used literature review, focus group discussions, interviews with key personnel and a baseline questionnaire survey of 500 nurses and midwives employed in the Trust. The study was conducted in the period from January to July 1998.

This report presents both an assessment of the early phases of the introduction of Beyond Hierarchy, and a series of baseline indicators which can be used in the future to check on change and progress of implementation. The remainder of the report is in three chapters and an annex.

- **Chapter 2** describes the main aspects of the Beyond Hierarchy project and its relationship to shared governance.
- **Chapter 3** describes the research methods and reports on the main findings of the study.
- **Chapter 4** highlights key issues for further consideration.
- **Annex 1** provides a literature review of shared governance in nursing and midwifery.

It is important to note that this report presents an assessment of the early phases of implementation of Beyond Hierarchy at North Staffordshire NHS Trust. As such it is not an evaluation of a fully implemented project, but highlights issues of relevance to achieving successful implementation.

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1. The Department of Health (1997) *The New NHS: Modern, Dependable.* London: The Stationery Office

Chapter 2: Beyond Hierarchy and Shared Governance

Beyond Hierarchy at North Staffordshire Hospital NHS Trust

The stimulus for the Beyond Hierarchy project occurred following discussions between the Executive Director of Nursing and Quality and Senior Nurse Managers at the Trust, where it was agreed that the successful development of nursing and midwifery had to lie with empowering every nurse and midwife to make an effective contribution to the debate.

Two 2-day workshops for Sisters and Charge Nurses were held in March 1997. This was devoted to setting the profession within the context of the challenges facing the trust and the NHS. Working groups were established with external facilitation. Their remit was to identify the contribution all nurses and midwives could make to achieve the aims and objectives of the Trust's Business Plan and the professional agendas, with the focus on identifying how to improve patient care. Staff were also able to meet Executive and Non-Executive Directors, Clinical Directors and other senior personnel.

Following the workshop, a Steering Group was established, comprising all registered nursing and midwifery Grades. This group organised what came to be known as the "Open Space" event. Approximately 280 nurses comprising one G grade and one other nurse or midwife from every ward and department attended. Short presentations, outlining their vision of the NHS in the year 2002 were given by a Consultant Surgeon, Director of Commissioning, Community Health Council (CHC), complaints manager and a primary care specialist. The event was also externally facilitated. Nurses and midwives spent the rest of the day identifying professional issues of concern and brainstorming possible actions. Again, there was an opportunity at the end of the day to meet senior members of the Trust in an informal setting.

The Open Space event identified over 40 issues regarded as important by the attending nurses and midwives. These issues were grouped in four key themes:

- Clinical Supervision
- Practice Development
- Professional Identity
- Communication

A project group was established for each theme, facilitated by a group leader and with a nurse manager as mentor. The groups comprise registered nurses and midwives of all grades who wish to become involved on a voluntary basis. The scope of Beyond Hierarchy is currently limited to qualified nursing and midwifery staff, although it is intended that it be extended to cover other staff groups.

Progress is being monitored by the Steering Group established to co-ordinate activity and maintain oversight. Each group is developing project plans and targets for action, which will be subject to evaluation. The aim is that plans will be widely disseminated throughout the Trust.

The Steering Group has met regularly since June. An action plan was agreed which aims to ensure that the 40 issues of concern identified at the Open Space event moved forward through the four working groups which have been established. Details of the event and the issues raised have been cascaded throughout the organisation, using team briefs and ward level meetings, and nurses have been actively encouraged to become involved in the working groups. A Beyond Hierarchy newsletter has been introduced, with the first issue disseminated to staff in December 1997, and a second issue being produced in March/April 1998.

A brief synopsis of the groups' activity, prepared by the chairs of the groups, is set out below.

Professional Identity

The group has begun collating information on job descriptions throughout the Trust to formulate an index, and is organising a multidisciplinary conference on good practice. The style of management of the conference is not hierarchical, but led by more junior staff in a widely disseminated group:

> *"The conference will be of a multi focal, multidisciplinary nature. Its aim being more supportive collateral ways of working which involves the whole workforce taking a much more proactive creative approach to their working role by being "involved" and reaching out beyond traditional hierarchical boundaries. It is the "creativity" in progress in the professional identity groups work which has enabled staff development, a shared vision as well as making a more effective contribution to the organisation".*

Clinical Supervision

The clinical supervision group has an identified chair and co-chair with representation across the directorates.

The terms of reference and clarification of the principle aims of the group have now been re-evaluated and agreed by group members. The group has set targets to be achieved by October 1998:

- A Clinical Supervision Roadshow
- Acknowledging and maintaining areas of good practice throughout the Trust
- Maintaining a register of clinical supervisors
- Setting up a database of clinical supervision literature
- Identifying individual training needs of team members

Further goals set by the group for achievement by November 1998 involve:

- The development of a clinical supervision resource pack to include education and guidelines
- 3 monthly evaluation of the groups' achievements
- A review of the education surrounding clinical supervision
- Examine issues relating to the time and place of clinical supervision
- Develop a subsequent action plan for December through until February

Communication

The group is currently focused on 3 areas - complaints, communication and customer service.

> *"To develop an ongoing communication strategy which is effective, appropriate, accessible and responsive to both users and providers of the service"*

The goals include highlighting areas of good practice, identifying mechanisms for sharing this throughout the Trust, the involvement of lead professionals involved with patient partnership and review all written communication to patients across the Trust.

Customer Service

> *"To promote excellence in customer services"*

The goals include accessing other customer care services, literature search and identifying training needs.

Complaints

"An environment in which comments and suggestions made by service users are welcomed and responded to positively"

The goals include developing marketing strategies, evaluate training needs, exploring mechanisms of sharing good practice and good outcomes, and developing patient/relative focus groups.

A study day has been recently organised by the groups related to complaints management and training with speakers from the UKCC, RCN, Trust solicitors and patient ombudsman.

The Beyond Hierarchy project shares some but not all of the overall philosophy and main characteristics of shared governance. The term 'Beyond Hierarchy' was used by Neubauer (1998) to describe a model of shared governance. She describes the activities of a network group at the King's Fund Management College, London, who are developing a version of shared governance which will be specifically applicable to the UK.

Beyond Hierarchy has most in common with the councillor model (described in the review of the literature), although at North Staffordshire NHS Hospitals Trust unit or ward based councils have not been established. Instead, there are four groups that meet to work on the themes described above (Clinical Supervision, Practice Development, Professional Identity & Communication), with an over arching Steering Group.

Staff at North Staffordshire have been active in discussing approaches to empowering staff with nurses and midwives at shared governance sites in the UK, such as Leicester General Hospital and the Royal Hospital for Sick Children in Edinburgh. A study tour of shared governance sites in the United States is also under consideration.

The methods used by the research team were intended to meet the objectives of undertaking *"a descriptive case study assessment and demographic/attitude baseline survey of the initial phase of introducing the Beyond Hierarchy initiative at North Staffordshire Hospitals NHS Trust"*. The timetable for the study was as follows:

January 1998	Preparatory meetings with key stakeholders
February 1998	Structured interviews with individual members of staff
March 1998	Structured focus group discussions with groups of employees; questionnaire design
April 1998	Questionnaire piloted; questionnaire revised
May 1998	Questionnaire survey of nurses and midwives
June 1998	Survey analysis; draft report
August 1998	Report completed

The main focus of the case study assessment was the questionnaire survey of 500 nurses and midwives at the Trust. The sample was structured to include nurses and midwives from all locations within the multi-site trust, and to be representative of all clinical grades. The objectives of the survey were to provide baseline demographics and attitudinal measures which could be referred to in any subsequent evaluation of Beyond Hierarchy, and to give an indication of the experiences and opinions of staff in relation to the early phase of Beyond Hierarchy.

The survey was conducted in May/June 1998, approximately one year after the 'Open Space' event and the beginning of Beyond Hierarchy at North Staffordshire, and several months after the project groups had become operational. It also coincided with the dissemination of the second edition of the Beyond Hierarchy newsletter. The key questions examined in the survey were:

- what are the current attitudes and experiences of the nurses and midwives in relation to their careers, work environment and professional activities?
- what is their level of awareness of Beyond Hierarchy?
- what is their extent of participation in Beyond Hierarchy?
- what are their perceived barriers and incentives to participation in Beyond Hierarchy?
- what are their perceived attractions and limitations of Beyond Hierarchy?

The survey provided a structured method of acquiring feedback from a large number of nurses and midwives at the Trust, in a format which would enable a follow up study at a later date. However, the survey was also a means of providing a 'snapshot' picture of the impact of Beyond Hierarchy on nurses and midwives at an early stage of implementation. It was anticipated that this would provide lessons for those actively involved in the project groups and steering groups of Beyond Hierarchy.

The literature review on shared governance conducted for the study (Annex 1) highlighted that shared governance is relatively widespread in the United States. Whilst there have been many claims made of the potential benefits, there are few published evaluations of implementation of shared governance. The main lessons from the review were that many authors had underlined the need for good communication in implementation, and continued support to enable the shared governance process to reach maturity and to fully involve staff. There was also a common theme that shared governance cannot be 'imposed' on staff. Many authors argued that it has to become an integral part of the process of the organisation of nursing and midwifery care, rather than being felt by staff to be external to that process.

The methods used in the early stages of implementation of Beyond Hierarchy at North Staffordshire suggest that these lessons have been learned. The initial phase, designed to raise interest in the project, was primarily linked to the 'G' grade sisters/charge nurses and managers. However, the subsequent focus has been on voluntary participation by all grades of nurses and midwives and leadership within the four project groups and the steering group.

Interviews and focus group discussions conducted with staff by the researchers at North Staffordshire in February/March 1998 revealed that some staff continued to have some residual concern that Beyond Hierarchy was a 'management' initiative, but that many now regarded it as a broader issue for all staff. In fact, it could be argued that one potential risk of the high degree of voluntarism encouraged at North Staffordshire is that it could lead to a lack of focus within the project groups, as they are largely autonomous, and have a rolling membership. This places a high level of responsibility on project group chairs to maintain impetus and direction, and emphasises the need for good communication between groups and with all staff. The role of the steering group will also be central to successful implementation. Arguably, this group has less control and influence than an integrating council in the 'classic' councillor model of shared governance, with which the North Staffordshire approach shares other common characteristics. It will be imperative to the successful implementation of Beyond Hierarchy that the steering group operates effectively, co-ordinates the work of the project groups, and supports a comprehensive programme of communication.

Another characteristic of Beyond Hierarchy, which highlights its voluntary nature, and differentiates it from many shared governance sites (including many of those in the UK) is that there is no project co-ordinator whose main day-to-day responsibility is facilitating the implementation and maintenance of the project. This responsibility is shared between the steering group members. Whilst this assists in highlighting voluntarism and shared commitment, it places an additional responsibility on steering group members to manage collectively the overall process of implementation whilst also undertaking their other duties.

Beyond Hierarchy was chosen as the title of the project because there was a recognition that the Trust was attempting to initiate a cultural shift in the operation of nursing and midwifery care. Organisational cultures do not change overnight. The survey was conducted at an early stage of what will be a continuing process of attempting to secure staff involvement. The early phase of Beyond Hierarchy will be assessed in the next chapter, and lessons for subsequent implementation will be discussed.

Chapter 3: Survey Results

A total of 500 nurses and midwives at North Staffordshire Hospitals NHS Trust were surveyed in May/June 1998. The overall response rate was 60 per cent. Two subgroups were covered in the survey;

- an "active group" – which covers those who have participated in Beyond Hierarchy groups (79 responses) and
- a "non-active" group - those who have not been actively involved (220 responses).

The active group was selected on the basis of their current or recent involvement whilst the non active group was a random sample of qualified nursing and midwifery staff at the Trust. Many of the results presented in this chapter differentiate between the two groups, in order to highlight any variations in characteristics or opinions.

The Respondents

The demographic characteristics of the two groups are shown in Table 3.1. These characteristics were examined to check for any significant differences between the two groups.

Table 3.1
Demographic characteristics

		Active (%)	Non-Active (%)
Gender: (%)	Female	96	94
	Male	4	6
Age: (%)	< 25	6	5
	25 - 29	8	15
	30-34	22	24
	35 -39	27	16
	40 - 44	17	17
	45 - 49	14	11
	50 +	8	12
Average Time at North Staffs		11.7 years	11.5 years
Average Time in Current Post		5.7 years	5.6 years
Baseline (n=)		**79**	**220**

There was little difference in the demographic characteristics of the two groups, in terms of gender, age, or length of time working in the trust or in current post. The North Staffs nursing and midwifery workforce is relatively stable, with low turnover and a high average length of service. The only difference of note was that the "non active" group has a more polarised age profile, with proportionately more older and younger nurses and midwives than the "active" group.

Table 3.2
Work Location

		Active (%)	Non-Active (%)
Site:	City General	65	74
	Royal Infirmary	26	19
	Other/All	9	8
Area of Work:	Ward	60	72
	Many Wards	20	10
	Department/Unit	3	2
	Outpatients	13	10
	Theatres	5	3
	Community/Mixed	-	3
Baseline (n=)		**79**	**220**

Examination of work related characteristics (Table 3.2) does highlight some, but not marked, variation between the two groups. A slightly higher proportion of active respondents were based at the Royal Infirmary, and these respondents were also more likely to report that they worked across wards rather than in a single ward. The origins of the Beyond Hierarchy project were in meetings of nurse managers and ward sisters, and the groups are structured with a senior nurse manager as mentor in each group. Feedback at focus groups suggested that some staff nurses still regard Beyond Hierarchy as a "ward manager issue" and some of the group participants reported feeling 'outnumbered' by senior grades of staff.

Table 3.3
Job Title and Grade

		Active (%)	Non-Active (%)
Job Title:	Staff Nurse/Midwife	48	77
	Enrolled Nurse	-	5
	Ward Manager	23	11
	Clinical Nurse Specialist	10	3
	Senior Manager	5	1
	Other	14	4
Grade:	C	-	2
	D	13	34
	E	30	38
	F	9	11
	G	30	11
	H	12	2
	I	3	-
	Manager	5	1
Baseline (n=)		**79**	**220**

This finding is reinforced when the job title and grade of respondents is examined (Table 3.3). Half of the active respondents were in the ward manager, manager, clinical nurse specialist or "other" (education/practice/support) categories, in comparison to one quarter of the non active respondents. The grade profile of the active respondents was also higher, but it should be noted that nearly half (43%) of active respondents were in grades D and E. The grade mix of the Beyond Hierarchy groups also contributes to the different age profile of active respondents.

These findings give some support to the notion that Beyond Hierarchy was closely linked to the ward manager group, but the overall response demonstrates that it is not exclusively an issue for senior grades. There are twice as many staff nurses active in Beyond Hierarchy as there are ward managers. However, the fact that it is restricted to qualified nursing and midwifery staff only was an issue of concern for some of the focus group participants. Some staff felt that non involvement of Health Care Assistants (HCAs) or other staff groups, was not in the spirit of Beyond Hierarchy.

Table 3.4
Type of Employment

		Active (%)	Non-Active (%)
Contract:	Permanent	96	97
	Fixed Term	4	1
	Bank/Other	-	2
	Full Time	89	65
	Part Time	11	36
Shift Work?	Yes	61	79
	No	39	21
Baseline (n=)		**79**	**220**

An examination of type of employment (Table 3.4) reveals that active respondents were more likely to work full time, and less likely to work shifts than non active respondents. This reflects the difference between the two groups in terms of job title and grade, but also highlights a challenge to the steering group and project groups increase the active participation of part time staff, and lower grade nurses and midwives in Beyond Hierarchy.

Roles and Responsibilities

It was apparent from examining the characteristics of the respondents that those active in Beyond Hierarchy were more likely to work full time, and be in grades 'E' to 'I' than "non active" respondents, but that there was little difference between the two groups in terms of other demographic characteristics. These differences and similarities are also highlighted when the roles and responsibilities of the two groups are examined.

A lower proportion (83%) of active respondents was involved in direct patient care than non active respondents (95%), reinforcing the fact that there were a higher proportion of management grades in the active group; however, it should be noted that the vast majority of active respondents were involved in direct clinical care. Similarly, "active" respondents were less likely to report that they were never in charge of wards than the non active group.

Control and Communication

Shared governance is often highlighted as a means of more fully involving staff nurses and midwives in decision making on aspects of clinical care and professional practice. At this early phase of implementation of Beyond Hierarchy, the nurses and midwives participating in the survey were asked to indicate their opinions about which groups were most involved in decision making in the Trust. The pattern of responses to these questions gives an indication of the main locus of control over different aspects of nursing and Trust activity. It also enables contrast to be made between the responses of "active" and "non active" nurses and midwives.

Two areas of activity were covered in the responses - aspects of nurses' work, and broader aspects of clinical care at the Trust. The pattern of responses in relation to nurses work is shown in Table 3.5.

Table 3.5
Who is involved in the following decisions?

	Staff Nurses & Midwives %		Ward Managers %		Senior Nurse Managers %		Directorate Managers %		Trust Board %	
	A	NA	A	NA	A	NA	A	NA	A	NA
Use of patient donations	45	34	86	75	65	52	62	48	34	30
Clinical role of registered nurses/midwives	43	28	71	56	85	81	61	53	34	27
Roles of HCAs	45	33	79	70	74	70	44	45	31	20
Addition of activities into nurses/midwives' roles	40	28	69	51	86	76	64	65	38	33
Nurse uniforms	62	39	70	60	82	72	46	55	28	32
Staffing levels	16	7	63	58	85	80	56	63	19	27
Use of bank/agency staff	29	13	82	70	82	77	30	46	13	14
Grade mix on the wards	13	11	76	75	82	73	39	43	9	10
Job descriptions	9	6	52	46	90	81	46	60	19	25
Length of shifts	33	12	67	46	73	68	39	58	24	33
Off-duty	59	54	97	96	30	25	11	9	3	2
Access to training	34	17	87	76	91	88	39	53	15	20

A = Active Staff (n=79) **NA** = Non Active Staff (n=220)

It is apparent from the responses of both active and non active groups that in most cases, ward managers and senior nurse managers were most likely to be highlighted as being involved in decision making. Staff nurses/midwives were least likely to be highlighted on most items.

Respondents from the active group were generally more likely to indicate they believed that staff nurses/midwives and ward managers were involved in decision making on specified activities. Likewise, larger proportions of the active group reported that Senior Nurse Managers were involved in decisions. The difference in response between the active and non active groups was evident in relation to nearly all items. However, even in the active group there were only two items ('nurses uniforms' and 'off duty') which were highlighted by more than half of respondents as involving staff nurses and midwives.

The non-active groups were more likely to report that Directorate Managers were involved decisions than those in the active group.

The overall pattern of responses in Table 3.5 provides an opinion baseline against which to track any future attempted changes in the locus of decision making in the Trust. At present, on most items, the response suggested that non active nurses and midwives believed that they were not heavily involved in decision making. Deciding off-duty, decisions on nurses uniforms, and use of patient donations were most likely to be reported as involving staff nurses and midwives. Active nurses and midwives were more likely to report that they believed that they were involved in decision making.

Table 3.6
Who is involved in the following decisions?

	Staff Nurses & Midwives %		Ward Managers %		Senior Nurse Managers %		Medical Staff %		Directorate Managers %	
	A	NA	A	NA	A	NA	A	NA	A	NA
Discharge policy	61	49	68	67	73	67	58	46	44	34
Recruitment of medics	0	0	3	1	14	12	95	87	73	73
Recruitment of nurses/midwives	13	4	82	63	92	94	16	10	32	57
The purchase of new equipment	29	22	86	78	85	79	43	27	67	72
Referral to Clinical Nurse Specialists	76	71	73	80	13	15	52	39	5	2
Referral of patients to dietician	85	89	68	52	2	5	58	50	5	< 1
Do not resuscitate policy	46	32	46	36	14	15	89	95	11	12
Type of dressing used	86	82	67	62	16	18	92	51	5	6
Admission of particular cases	25	22	53	34	24	22	91	89	19	13

A = Active Staff (n = 79) **NA** = Non Active Staff (n = 220)

In relation to broader aspects of service delivery, the response was not dissimilar (Table 3.6). The pattern of response varied markedly for different items, but active nurses and midwives were more likely to report involvement in decision making of most groups than were non active respondents. In relation to the reported involvement of staff nurses and midwives, the variation between active and non active staff was less marked than in Table 3.5, and on some items (referral to clinical nurse specialists, referral of patients to dietician, type of dressings used) there was a marked majority response from both groupings.

Table 3.7
What issues would you most like staff nurses and midwives to have more involvement in?

Active Group	Non-active Group
1. Addition of activities to nurses / midwives roles	1. Staffing levels
2. Access to training	2. Purchase of new equipment
3. = Clinical Role of Nurses/Midwives = Staffing levels	3. Grade mix on the wards

The respondents were asked to indicate which three items from Tables 3.5 and 3.6 they would most like staff nurses and midwives to be more involved in. This response (Table 3.7) gives an indication of the differences between the two groups. The active group were more likely to highlight what could be termed 'professional' issues, linked to role and training, whilst the non active group were more likely to highlight work related issues - equipment purchase and staffing levels/grade mix. Staffing levels were highlighted by both groups. It is also important to note that the larger non active group highlighted three issues which were currently ranked very low in Tables 3.5 and 3.6, in relation to perceptions about the current level of staff nurse/midwife involvement in decision making. This suggests these issues are regarded as important by most respondents, but that they do not believe they currently have an input into decision making in these areas.

Communications and Beyond Hierarchy

Respondents were asked to rate the usefulness of various media, in terms of telling them what is happening in the Trust. The results are presented in Table 3.8.

Table 3.8
How useful do you find each of the following for telling you about what is happening in the Trust?

	Very useful %		A bit useful %		Not at all useful %	
	A	NA	A	NA	A	NA
Senior nurse managers	36	21	43	54	20	26
Ward manager	60	60	36	35	4	5
Colleagues	55	63	43	33	3	4
Trust wide news (TWN)/e-mail	35	27	51	48	14	25
Connections	26	21	57	55	16	23
Cascade briefings	27	13	60	51	14	36
Beyond Hierarchy Newsletter	37	23	58	62	5	16
Memos	36	40	51	54	14	5

A = Active Staff (n=79) **NA** = Non Active Staff (n=220)

Both groups rated ward managers and colleagues as the most useful sources of information. Active respondents were more likely to give a positive response, but overall, the pattern of responses from both groups was generally positive about the different methods of communication being used in the Trust. The Beyond Hierarchy Newsletter, which focuses specifically on Beyond Hierarchy issues rather than being a broad based newsletter, was rated "useful" or "very useful" by 95 per cent of active respondents and 84 per cent of non active respondents.

Participation in Beyond Hierarchy

The responses to the survey have been presented as coming from "active" and "non active" groups in relation to their level of involvement with Beyond Hierarchy. The overall pattern of involvement in Beyond Hierarchy at the time of the survey is shown in Table 3.9.

Table 3.9
Level of Participation in Beyond Hierarchy

	Active (%)	Non Active (%)
I've never heard of it	-	3
I've heard of it but don't know much about it	-	40
I know about it	-	57
I have been to one or two meetings, but currently not involved	52	-
I am currently a member of one of the groups	48	-
Baseline (n =)	**79**	**220**

Membership of the groups is voluntary, and therefore fluid. At the time of the survey, approximately half of the "active" group reported that they were actually members of one or more groups. In the non active group, only a small minority (3%) reported they had not heard of Beyond Hierarchy, whilst 57 per cent indicated that they knew about it. The overall response suggests that the communication strategy for Beyond Hierarchy has been broadly successful. The Beyond Hierarchy newsletter and ward manager briefings were most commonly reported as the main source of information on Beyond Hierarchy.

The majority of respondents indicated that they either knew about Beyond Hierarchy, or had become directly involved in the project. It is apparent that currently only a minority of staff are actively involved in Beyond Hierarchy. The main challenges for the project teams are to encourage more of the non active respondents to become involved, and to maintain the involvement of those in the active group.

What can be done to encourage more staff nurses and midwives to become actively involved in Beyond Hierarchy? The most common responses to the question of why they were not currently involved in Beyond Hierarchy are shown in Table 3.10.

Table 3.10
If you have not been involved in any of the groups, please describe why not (most common responses)

1. **Don't have time**	- too many other commitments - too busy with other projects
2. **Lack of Advertising/Information**	
3. **Not Invited**	

These responses highlight two issues which were also reported in the focus groups. Some nurses and midwives indicated they would wish to be more fully involved, but find it difficult to find the time because of their other work and domestic commitments. The second main barrier to participation relates to a lack of detailed information. The positive aspect of this response for the project teams is that there does not appear to be an inherent disregard for Beyond Hierarchy amongst non-active nurses and midwives. Only four respondents, out of 220 'non active' staff, indicated that they were not interested in Beyond Hierarchy. The reported barriers are work related and communication based, rather than psychological, and therefore are more open to direct intervention. The third reason given for not being involved was that they were not invited. Whilst the groups are theoretically open to all staff, the history of the Beyond Hierarchy initiative has shaped the membership of the groups. The Beyond Hierarchy groups subsequently made use of the Open Space Day participant list to target interested staff. These staff were invited to join the groups and given information about them. The fact that some staff did not receive this information may have led to them feeling 'not invited'.

Respondents were also asked to indicate what would most help them to get more involved in Beyond Hierarchy (Table 3.11).

Table 3.11
What would most help you to get more involved? (non active group - most common responses)

1. **More time off from ward**
2. **More information**

Two responses were commonly reported. Unsurprisingly, they are the mirror image of responses to the previous question, and highlight the perception that allotted time away from ward work, and more information would enable and encourage more staff nurses and midwives to become involved in Beyond Hierarchy. This reinforces the findings from the previous table, and highlights the scope for management intervention.

The future intentions of respondents in relation to Beyond Hierarchy was examined when respondents were asked to indicate if they wished to become more involved in the project (Table 3.12).

Table 3.12
Would you like to become more involved in Beyond Hierarchy?

	Active (%)	Non Active (%)
Yes	46	19
No	30	31
Don't Know	24	50
Baseline (n =)	**79**	**220**

The response indicates that about a third of active members and the same proportion of non active members do not intend to become more fully involved, and that nearly half (46%) of active members indicate that they would like to be more involved. The main challenge for management will be to stimulate participation amongst the large group (50%) of non active members who are currently undecided. Given the results reported above, this challenge will be best met by further detailed communications, briefings by ward managers, and the provision of support to staff to enable them to balance other work commitments with participation in Beyond Hierarchy.

A suggestion that came out of the focus groups, was that involvement in Beyond Hierarchy could be increased by offering staff a wider range of methods for taking part in it (eg. through more effective two-way communication with the groups by e-mail). At present, involvement primarily takes the form of attending meetings, which as the survey shows, can be difficult for some staff.

Unlike other applications of shared governance that follow the councillor model, the thematic groups adopted in Beyond Hierarchy are not linked to ward or unit based councils. There is thus no formalised structure to ensure feedback to staff on the wards or to allow staff to have an input to the groups via a representative from their own work area. The Trust need to consider when implementing broader change, how best to enable more staff to participate in Beyond Hierarchy.

Views of nurses and midwives about their working lives

This section presents general attitudinal findings from the whole sample of respondents. The questionnaire was designed to elicit staff views about their working lives. This was done by asking respondents the extent to which they agreed with a series of statements referring to aspects of work life, using a five-point scale from "strongly agree" to "strongly disagree".

The results serve several different purposes. Firstly they can be used to describe the backdrop for the Beyond Hierarchy initiative. How do nurses and midwives at the Trust feel about their roles, workloads, and the Trust itself? Staff's views and experiences of Beyond Hierarchy specifically, can then be placed in the more general context of their views about working at the Trust. It may be that some of the views expressed about the Beyond Hierarchy initiative reflect more generally held views. Alternatively, we can use the results from the attitude statements to discover if their views on specific aspects of Beyond Hierarchy contrast with their views of work in general. For example, how do nurses feel about broader based communications at the Trust? Does this differ from how they view the communication provided regarding Beyond Hierarchy? To achieve this end, the results will be presented thematically, grouping the statements that cover the same topic.

The attitudinal data will be supplemented by the more 'factual' data drawn from other elements of the questionnaire, where relevant.

The second purpose of the attitude items is to get a baseline of nurses' and midwives' views, to help explore the impact of Beyond Hierarchy. The literature on shared governance suggests that its impact can go beyond simply the changing the mechanism for decision making, to have an effect on staff satisfaction and enhance the performance of individual staff and the organisation as a whole. Staff who are more actively involved in decision making are reported to demonstrate greater job satisfaction. Do staff who have been actively involved in Beyond Hierarchy currently have a different outlook on their working lives than those who have not? The attitudinal data could be revisited at some time in the future, when Beyond Hierarchy is more firmly established, to see if it has had an effect on staff satisfaction.

Thirdly, we can use the results to find out which issues staff at North Staffordshire are least or most satisfied with. They can be placed in rank order of level of satisfaction, to identify the issues that are associated with greatest strength of feeling. Again, the data could be revisited in future surveys, to see if the 'league table' of views changes over the coming years. Revisiting the thematic data would show if the level of satisfaction with particular aspects of working life changes over time, whilst looking at the 'league table' would allow us to examine the relationship between different aspects of work life.

Throughout this section, a lower "score" corresponds to higher satisfaction. This is because the coding on negative items has been reversed for the production of an average. A lower score indicates satisfaction across all the constructs being examined, since agreeing with a positive item is the same as disagreeing with a negative item. For example, strong disagreement with the item 'I am worried I may be made redundant' indicates that the respondent is positive about the threat of redundancy.

The mean scores on all attitude items are presented in the statistical appendix, for the entire sample and by beyond hierarchy participation. The results for the 'top' 10 items are presented below in Table 3.13. A low mean score indicates satisfaction and a high score corresponds to dissatisfaction.

Table 3.13
Items with greatest reported satisfaction

	Rank Position	**Strongly Agree %**	**Agree %**	**Mean Satisfaction Score**	***N = (100%)***
I know the standards of work expected of me	1	33	65	1.71	*297*
I know what procedures to use to get my job done	2	31	65	1.77	*298*
You need to be a nurse to do my job	3	44	41	1.85	*298*
I have the opportunity to use my initiative at work	4	23	70	1.87	*298*
I feel I can talk to the rest of the team	5	21	65	1.99	*296*
I feel I fit in here	6	18	64	2.04	*299*
I have enough support from competent colleagues to do my job	7	22	61	2.04	*294*
*Harassment by colleagues is an issue at work for me	8	3	8	2.06*	*296*
*I don't know where to turn for help	9	2	6	2.06*	*295*
Most days I am enthusiastic about my job	10	18	65	2.08	*296*

* = negative statements reversed to produce a mean 'satisfaction' score

The results show that nurses and midwives at the Trust are most satisfied with their jobs and the people they work with. They are confident in their knowledge of their own jobs and feel that they fit in and are well supported by colleagues.

Table 3.14
Items with least reported satisfaction

	Rank Position	Strongly Agree %	Agree %	Mean Satisfaction Score	N =
I have to work very hard in my job*	61	36	49	4.17*	*297*
Considering the work I do I am well paid	60	2	10	3.79	*298*
Its always a rush to get things done*	59	19	42	3.62*	*297*
It will be very difficult for me to progress from my current grade*	58	18	43	3.54*	*297*
My workload is too heavy*	57	13	33	3.43*	*293*
Senior managers don't seem to know what is going on at ward level*	56	15	30	3.28*	*297*
There are few nursing opportunities in this Trust beyond ward manager level*	55	9	33	3.28*	*297*
I often feel guilty about leaving at the end of a shift*	54	10	34	3.12*	*293*
I rarely get praised for what I do*	53	9	32	3.11*	*299*
Managers appreciate the realities of patient care	52	3	32	3.08	*298*

* = negative statements reversed to produce a means 'satisfaction' score

Dissatisfaction centres around workloads, being appreciated (in terms of pay, praise or an appreciation of the realities of patient care) and opportunities to progress (Table 3.14).

Table 3.15
Communication

	Strongly Agree %	Agree %	Disagree %	Strongly Disagree %	Mean	N = *(100%)*
I am kept informed of what is going on in the organisation	12	52	18	3	2.48	*295*
Suggestions for change are welcomed where I work	12	57	10	3	2.35	*298*
I feel happy to talk through problems with my manager	13	51	14	3	2.42	*298*
Management respond to the concerns of nursing staff	4	33	28	8	3.02	*297*
Suggestions I make are listened to	5	59	10	1	2.42	*298*
My ward manager listens to staffs views	13	56	5	4	2.30	*284*
I am satisfied with my involvement in decisions that affect my work	6	54	10	3	2.51	*295*
I feel I can talk to the rest of the team	21	65	5	0	1.99	*296*

Note: For presentational clarity, the percentage of respondents indicating "neither" as a response is not shown.

Nursing and midwive staff were generally positive about communication (Table 3.15). They felt they could talk to the rest of the team and their own manager, that they worked somewhere that was receptive to suggestions for change and are involved in decisions, and that they were kept informed of what was happening in the organisation. A higher proportion of G grades (79per cent of 47) agreed that they were kept informed, whilst staff nurses and midwives were least likely to feel that their suggestions were listened to – 64 per cent compared with over 80 per cent of ward managers and senior grades of staff.

The aspect of communication with which they are least satisfied is the extent to which management respond to the concerns of nursing and midwifery staff – 36 per cent felt that this did not happen. The way in which management responsiveness was perceived varied greatly by seniority, with 83 per cent of senior managers giving a positive response, 51 per cent of ward managers and less than a third (31 per cent) of staff nurses.

Working part-time was also associated with a more negative view of communication. Fewer part-timers report that they feel they can talk to the rest of the team (77 per cent compared with 89 per cent of full-time staff). They are also less likely to feel that suggestions they make are listened to (53 per cent of staff working part-time and 70 per cent of full-time staff agreed with this statement).

One in two (49 per cent) part-time staff are neutral or dissatisfied with the level of involvement they have in decisions that affect their work, whereas almost two thirds (64 per cent) of full time staff are happy with their involvement in decisions.

These findings have implications for Beyond Hierarchy; as they highlight the staff that are currently least satisfied with communication, who would thus have most to gain from the success of an initiative aimed at increasing opportunities for all staff to 'have a say'.

Table 3.16
Management

	Strongly Agree %	**Agree** %	**Disagree** %	**Strongly Disagree** %	**Mean**	***N* = *(100%)***
Managers here want what's best for patients	14	48	13	3	2.44	*297*
Managers appreciate the realities of patient care	3	32	31	8	3.08	*298*
I feel happy to talk through problems with my manager	13	51	14	3	2.42	*298*
Management respond to the concerns of nursing & midwifery staff	4	33	28	8	3.02	*297*
Senior managers don't seem to know what is going on at ward level	15	30	23	5	3.28	*297*
My ward manager listens to staffs views	13	56	5	4	2.29	*284*

Note: For presentational clarity, the percentage of respondents indicating "neither" as a response is not shown.

Staff are generally positive about their interaction with own manager and believe that managers at the Trust want what is best for patients (Table 3.16). However, few respondents feel that managers appreciated the realities of patient care or know what is going on at ward level. Over a third (37 per cent) agreed that management respond to the concerns of staff, whilst just over a quarter (28 per cent) disagreed with this item.

Table 3.17
Relationship with the Trust – percentages and mean scores

	Strongly Agree %	**Agree** %	**Disagree** %	**Strongly Disagree** %	**Mean**	***N* = *(100%)***
I am proud to tell others I work at this Trust	8	44	5	2	2.49	*298*
I enjoy working at this Trust	8	55	6	1	2.35	*296*
Nursing and Midwifery staff are highly valued by the Trust	3	26	24	7	3.05	*296*

Note: For presentational clarity, the percentage of respondents indicating "neither" as a response is not shown.

The items presented in Table 3.17 give an indication of how staff feel specifically about North Staffordshire Trust. The results show that most staff enjoy working at the Trust and are proud to tell others it is where they work. There is less satisfaction with the extent to which nurses and midwives are valued by the Trust.

Table 3.18
Valued – percentages and mean scores

	Strongly Agree %	Agree %	Disagree %	Strongly Disagree %	Mean	*N = (100%)*
I get full credit for the work I do	4	35	26	3	2.89	*297*
Nursing and Midwifery staff are highly valued by the Trust	3	26	24	7	3.05	*296*
I rarely get praised for what I do	9	32	31	4	3.11	*299*
Considering the work I do I am well paid	2	10	38	28	3.79	*298*

Note: For presentational clarity, the percentage of respondents indicating "neither" as a response is not shown.

Table 3.18 looks at other items relating to their sense of being valued. Whilst the majority of staff are enthusiastic about their jobs and enjoy working at the Trust, they feel undervalued – both as a group and as individuals. Less than a third feel that nursing and midwifery staff are highly valued by the Trust and only 39 per cent feel they are given credit for the work they do.

At a more individual level, 41 per cent of nurses and midwives reported that they rarely get praised for what they do and two-thirds of all respondents felt that they were not well paid for the work they do.

The degree to which staff felt valued varied by grade. For example, 45 percent of ward managers felt staff were highly valued compared with only 21 per cent of the staff nurses/midwives covered by the survey. Likewise, lower grades of staff were more likely to express dissatisfaction with their pay.

Table 3.19
Job Security & Job Change – percentages and mean scores

	Strongly Agree %	Agree %	Disagree %	Strongly Disagree %	Mean	*N = (100%)*
Nursing and midwifery will continue to offer me a secure job for years to come	8	45	16	2	2.6	*295*
I am worried that I may be made redundant	0	5	54	17	2.18	*297*
I have a secure job	7	53	11	1	2.45	*296*
I would leave nursing if I could	9	16	34	18	2.63	*295*

Note: For presentational clarity, the percentage of respondents indicating "neither" as a response is not shown.

The majority of nursing and midwifery staff were positive about job security, with very few (five per cent) expressing concern that they may be made redundant (Table 3.19).

Younger staff were more likely to report that their jobs were secure (66 per cent of those under 40 agreed with this statement compared with 51 per cent of the 40+ age group). A larger proportion of senior grade of staff were worried about redundancy, and only 38 per cent of higher grades (F and over) felt that nursing and midwifery would offer secure employment in the future, compared with 60 per cent of D and E grades.

Respondents were also asked to describe their current employment plans. More than three-quarters (82 per cent) planned to stay for at least two years. Over half (54 per cent) reported that they planned to stay more than 5 years.

Taking the data on time in post into account, the survey shows the nursing and midwifery workforce to be very stable – with long average length of service, few people planning to leave and the majority feeling their jobs are safe.

Attitudes of 'Active' versus 'Non-active' Staff

How do the views held by those who have participated in Beyond Hierarchy meetings differ from those who have not? This section compares the two groups to see if there are any differences in their attitudes.

The survey reveals that Beyond Hierarchy participants differ from non-participants in their views on two main themes — overall job satisfaction and communication. The results from the items which differentiate participants and non-participants are presented in Table 3.20.

Table 3.20
Differing views of Beyond Hierarchy Participants – percentages agreeing

	% Agree		% Neither		% Disagree		*N* =
	A	NA	A	NA	A	NA	
Communication/Input							
I feel I can talk to the rest of the team	88	84	8	10	4	6	*296*
I feel happy to talk through problems with my manager	68	63	14	21	18	16	*298*
Suggestions I make are listened to	76	61	13	27	10	12	*298*
I have the opportunity to use my initiative at work	92	92	8	6	0	2	*298*
I am satisfied with my involvement in decisions that affect my work	73	56	17	30	10	14	*295*
Management respond to the concerns of nursing staff	53	32	18	29	29	38	*297*
I am kept informed of what is going on in the organisation	73	60	11	17	15	23	*295*
Overall satisfaction							
Most days I am enthusiastic about my job	91	79	4	13	5	8	*296*
There is a good atmosphere where I work	83	60	10	21	6	19	*297*
I feel I fit in here	84	81	15	15	1	4	*299*
Nursing and midwifery staff are highly valued by the Trust	41	25	37	42	22	34	*296*
There are few nursing/midwifery opportunities in this Trust beyond ward manager	42	42	23	43	35	15	*297*
My role is clearly defined	66	73	14	14	20	13	*299*

Beyond Hierarchy participants were more positive about communication and their opportunities to use their initiative or be involved in decisions (Table 3.20). Communication at all levels and in both directions was viewed more positively by the active group. In addition to feeling better informed and having a more positive view of their channels of communication, they were also more likely to believe that concerns expressed by staff would be acted on. Over half (52%) reported that management respond to concerns of nursing staff, whilst less than a third (32%) of non-participants held this view.

The second area differentiating respondents who had been actively involved in Beyond Hierarchy from non-participants, was overall satisfaction with their job and where they worked. Participants were more likely to enjoy their work and feel enthusiastic about it, report a good atmosphere at work, and feel that they 'fitted in'. Over two-fifths (41%) feel that nursing and midwifery staff are highly valued by the Trust, compared with 25 per cent of non-participants.

On the item 'I feel I fit in here' the difference between the groups relates more to the strength of feeling than a difference between agreement and disagreement. Whilst agreement (strongly agree, and agree combined) differs little, a mush higher proportion of the Beyond Hierarchy participants 'strongly agreed' with the statement – 32 per cent compared with 13 per cent of non-participants. This pattern is found on other items, where the differences between participants and non-participants stems primarily from differences in the numbers that 'strongly agree'.

Views about Beyond Hierarchy

The pattern of responses in relation to nurses' and midwives' views of Beyond Hierarchy is unsurprising (Table 3.21). "Active" respondents were more likely to 'agree' or 'strongly agree' with positive statements about Beyond Hierarchy.

Table 3.21
Views about Beyond Hierarchy

	Agree %		Neither %		Disagree %	
	A	NA	A	NA	A	NA
BH is an excellent idea	85	57	11	39	4	4
I am satisfied with the amount of information I have had about BH	74	44	10	23	15	32
BH is a good idea in principle but I don't think it will change anything	29	38	27	42	44	20
BH is well supported by managers	54	40	28	51	18	9
BH focuses on the topics that really matter to nurses/midwives	69	52	17	41	14	8
I have too many other commitments to get involved with BH	39	62	27	27	34	11
BH gives lower grade nurses/midwives a chance to have a say	78	56	10	33	11	11
BH is run by senior grades	31	26	10	40	59	35
BH is just a hype to make the Trust look good	13	29	27	47	60	24
BH will give real power to nurses/midwives	42	20	42	52	16	28
BH is a waste of time	8	8	23	44	69	48

A = Active Staff (n = 79) **NA** = Non Active Staff (n = 220)

However, what is particularly important about the response of the majority of non-participants is that even in this group there appears to be a generally positive (or at worst, neutral) view of Beyond Hierarchy. Over half of non active respondents agreed that Beyond Hierarchy was an excellent idea and that it gave lower grade nurses and midwives a "chance to have a say".

Given the earlier points made about the grade mix of the Beyond Hierarchy groups, it is interesting to note that only 27 per cent of those not involved in it and 31 per cent of the active group, considered that it was "run by senior grades".

In general, staff in grades 'C' and 'D' were less positive about Beyond Hierarchy. For example lower grades of staff were less likely to agree that BH gave them a "chance to have a say". They were also less satisfied with the information they had received – 37 per cent of D grades were satisfied with the information compared with 83 per cent of G grades.

As with their views on communication and involvement generally, part time staff were less positive about Beyond Hierarchy than full time staff. They were more likely to report that it was a hype, or waste of time and less likely to believe that it would give any nurses and midwives any real power. They viewed the information they have had on Beyond Hierarchy very differently – 59 per cent of full time staff were satisfied whilst only 36 per cent of part-time staff were.

The high ratio of "neither" responses on some items suggests that many respondents remain to be persuaded about some of the claimed potential benefits of Beyond Hierarchy, and are not yet sure if it is 'hype' or will give real power to nurses and midwives. Generally, however, there was a positive pattern of responses, with few non active respondents indicating that they believed Beyond Hierarchy was unfocused, or a waste of time.

Items where there appears to be scope for intervention to improve generally the views of nurses and midwives at the trust are in relation to the amount of information available and the level of support by managers.

Chapter 4: Key Issues

The early phase of implementation of Beyond Hierarchy has been underway for just one year. In that time, the four (now three) working groups have been established and the communication strategy, including the use of the Beyond Hierarchy Newsletter, has been developed.

The findings of this assessment of the early phase of implementation are broadly neutral or positive. The current attitudinal profile of nurses and midwives at the Trust shows that the majority of staff are satisfied with most aspects of their work; the areas of most concern are workloads and the extent to which they feel they are valued. Lower grade staff were generally less likely to report satisfaction than staff in higher grade positions.

Given that this study is only a 'snapshot' assessment and baseline indicator, there will have to be further evaluation to monitor progress and to track trends in attitudes and practice. It is evident, both from the North Staffordshire NHS Trust case study and from the literature on staff empowerment, that the process of change which has been initiated will evolve over time.

In relation to Beyond Hierarchy itself, there are a number of key messages from the focus groups and survey. The profile of the group currently active in Beyond Hierarchy indicates that nurses and midwives graded 'C' and 'D', and staff working part time are under-represented. These are also the groups that expressed least satisfaction with general communication and involvement in decision making in the Trust. One challenge for those currently involved in Beyond Hierarchy will be to attempt to increase the participation of these groups. Continued emphasis on internal communication will be required to promote the potential of Beyond Hierarchy to these staff, in terms that are relevant to their own practices and clinical environment. However, it was also clear that many of those currently involved are staff nurses and midwives; Beyond Hierarchy is no longer regarded by most staff as a "management issue".

The other positive note is that there is broad support for the concept of Beyond Hierarchy. Very few nurses and midwives reported that they disagreed that Beyond Hierarchy focused on important issues and was a good idea. In principle, most nurses and midwives are positive, or at worst, neutral about Beyond Hierarchy. The main issue is to secure the agreement and subsequent participation of the large group of nurses and midwives who remain neutral to Beyond Hierarchy. The survey results suggest that more information is required, and that there is also a need to examine how best to enable nurses and midwives to accommodate participation in Beyond Hierarchy with their other work commitments.

It is too early in the implementation of Beyond Hierarchy to provide a full evaluation; but the results so far point to the broad direction of implementation being satisfactory. There is a continued need to co-ordinate the activities of the groups, to support communications and to ensure that the commitment of line and senior management is maintained.

The review of literature on the implementation of nurse empowerment and shared governance (see Annex 1) suggests that full implementation takes two years or more. At the end of year one at North Staffordshire NHS Trust, there is sufficient positive evidence to suggest that further progress can be made, if the main lessons from the initial baseline survey are heeded.

Annex 1: Literature Review

Introduction

This literature review will set out to establish what is meant by shared governance (and where it originated), analyse reports of shared governance implementation, and discuss emergent issues. An initial search was undertaken using the terms 'shared governance' and 'empowerment', restricted to English language. The databases used were CINAHL, British Nursing Index, Medline, Social Sciences Citation Index and FirstSearch, and the search period was 1988-1998. Initially, nearly 500 articles were identified, of which approximately 130 articles were selected which appeared to have an evaluative component, or a description of the shared governance process implementation.

This search also highlighted articles describing participative management, the professional practice model, and self-managed work teams. For the purposes of this review, only published articles which either described and/or evaluated the implementation of shared governance were analysed. According to these criteria, 49 studies, which were obtained by the cut-off date, were included for detailed assessment.

What is shared governance?

There are many definitions of shared governance. The main thrust is that shared governance is a decentralised approach which gives nurses greater authority and control over their practice and work environment; engenders a sense of responsibility and accountability; and allows active participation in the decision-making process, particularly in administrative areas from which they were excluded previously. The primary aim is to support the relationship between the service provider (nurse) and patient (client). It is not a one-time implementation process, with a concrete, fixed set of rules, but rather an ongoing and fluid process, which requires continual assessment and revaluation to be flexible and adaptive to the environment. It has been described as a 'journey' (Porter-O'Grady, 1995) and a 'voyage' (Anderson, 1992), more a process than an outcome, more a vehicle than a destination (McMahon, 1992). Moore and Dugger (1995) see it not merely as a nursing practice model, but as a philosophy requiring support and development. Shared governance is often misunderstood as 'giving power to employees', which oversimplifies the reality of outcomes claimed to be obtained by effective shared governance organisations, such as the release of expert knowledge, motivation and action at the point of service. Proponents of shared governance emphasise that it requires that all players understand the principles, processes, and behaviours of shared leadership - and in shared governance, everyone is a player (Wilson, 1996)

Origins of shared governance

Shared governance has its origin in business and management literature, such as the philosophies of Deming (see e.g. Walton, 1986) and Kanter (see e.g. Laschinger, 1996), and emerged from the organisational work undertaken by people such as Maslow, Drucker, Herzberg and the Tavistock Institute (in Porter-O'Grady, 1995, p8). These studies looked at the design of organisations and their relationship to both the worker and the consumer, and emphasised that the structure of work had to be viewed from the point of service (point of care) outward, rather than from the organisation downward, in the traditional hierarchical manner. In essence, it is argued that success of any system is dependent on the investment, commitment and ownership of those stakeholders who are located closest to the point of service (or care). It is from this work that concepts like shared governance have emerged (Porter-O'Grady, 1995).

Shared governance has only relatively recently been implemented in the nursing arena, with the first US hospitals reportedly participating in the late 1970s/early 1980s (Christman, 1976; Cleland, 1978; McDonagh et al. 1989). Derivation from, and parallels and alliance with organisational/business management processes can be clearly seen in articles which describe shared governance in conjunction with Total Quality Management (TQM) (Gardner and Cummings, 1994); and Continuous Quality Improvement (CQI) (Murphy et al., 1995); and Continuous Improvement Process (CIP) (Horstman et al., 1994) and Collaborative Interactive Model (CIM) (Gomberg and Sinesi, 1994) ; as a form of participative management (Nakata and Saylor, 1994; Marion et al., 1995; Valentine, 1996; ; Moss and Rowles, 1997); and in terms of self-managed work teams (SMWT) (Perley and Raab, 1994; Norby, 1995; Morgan and Hanson, 1996; Owen, 1998) and the professional practice model (PPM) (Weisman et al., 1993; Nocar-Bowen and Ford, 1995; Hastings, 1995).

It is important to emphasise that shared governance was regarded as a method of better supporting the delivery of nursing care, rather than a 'new' method of delivering care. Kritek, cited in Schaffner and Bouman (1992, p212) suggested that the "concept of shared governance grew out of the recognition that staff nurses were dissatisfied not with nursing itself, but rather with the institutions in which they practised".

Nearly all examples of implementation to date have been from the United States, with a few in Canada, and it is only within the last 4-5 years that the concept has been introduced into the United Kingdom nursing environment

Types

There are a variety of shared governance models, but the bulk of the literature relates to the following four types: unit-based, congressional, councillor (councilor in US literature) and administrative, although in some cases only the latter three types are considered valid (Kovner et al., 1993; Naish, 1995). Porter-O'Grady (1989) suggests that unit-based models developed without an identified interface with the entire nursing department are a mistake. A summary of these four models can be seen in Figure 1.

Figure 1:
Shared governance models

Unit-Based	**Congressional**
■ Each unit establishes its own system ■ Multiple models may exist within one institution ■ No department-wide co-ordinating activities	■ All staff belong to a congress ■ Similar in structure to federal government ■ Committees submit work to "cabinet" for action
Councillor	**Administrative**
■ Co-ordinating council co-ordinates activities on department level ■ Unit councils reflect department councils ■ Staff nurses accountable for clinical decision making	■ Practice and management structures exist ■ Forum integrates work of councils ■ Councils submit work to executive council for decisions

Source: Yanko et al. (1995, p87)

'Beyond hierarchy' is a term used by Neubauer (1997) to describe shared governance and she reports on the network group at the King's Fund Management College, London, who are developing a version of shared governance (councillor) which will be applicable specifically to the UK, rather than a copy of the US model. However, to date no published literature is available relating to this version. For brief descriptive articles relating to British implementation, see for example Geoghegan (1995); Legg, (1996); Edmonstone (1998).

Hess (1994) argues that when governance is restricted to unit-based level it is incompletely shared. Although this model increases staff autonomy and participative decision making in clinical and administrative areas, e.g. staffing and quality monitoring, the overall organisational structure remains unaffected. However, several studies which utilised the unit-based system did so specifically with a view to subsequently extending it to other units, and/or throughout the organisation (Jones and Ortiz, 1989; Jones et al., 1993). This reiterates the point made by Porter-O'Grady (1994), who claims that the concepts which underpin shared governance assume that it will move towards others in the environment and seek to empower and include them in relationship building and decision-making.

Why implement shared governance?

Various rationales are reported for introducing shared governance. Nursing shortages is one reason given (Kovner et al., 1993). When staffing shortages occurs, the task of providing continuity and goal setting in patient care becomes more difficult, but the framework of shared governance applied on a patient care level is one method claimed to be the way to better guarantee delivery of quality care (McDonagh et al., 1989). Analyses of nursing shortages offer frequently cited reasons including a lack of autonomy in practice, low pay, poor prestige, and poor working conditions (Deremo, 1989), to which a major contributing factor may be the highly bureaucratic structures of hospitals. Shared governance, operating within a professional practice framework, is claimed to address the administration and practice factors contributing to these shortcomings (Dennis, 1991). Shared governance has been offered as a solution to the perceived problem of bureaucracy, by enabling nurses to assume responsibility for and authority over their practice (Porter-O'Grady, 1987).

Other major agents of change in the current healthcare climate are those of competition and regulation which place substantial constraints on the availability of resources, and have forced a redirection of management effort. Nurse executives must somehow deal with financial management concepts and practices in their planning, decision making and priority setting. However, not all decision making in health care is predicated on monetary value. Community needs, patient care, and quality of service are still important issues in the field, and must be addressed in decisions related to resource allocation (Dowd, 1988). Drawing on the knowledge and aspirations of participants will optimise the validity of decisions made, simultaneously bonding people to a commitment of support for priorities selected, such as patient care, and quality of service.

In the UK, there is a trend toward increased team working in general practice. Stott and Walker (1995) argue that self managed work teams are an emerging trend in many organisations, and are often associated with the term 'empowerment'. Certainly, as a response to escalating problems of pricing and management constraints, co-operative and democratic teamwork would seem to offer one way of attempting to reduce costs and increase cohesiveness and autonomy.

Additionally, "Shared governance has been credited with being the answer to retention, nursing shortages, advancing the nursing profession, and expanding nurses' autonomy for their practice and work life" (Rose and Reynolds, 1995, p1).

With reference to the 49 articles mentioned in the Introduction, this assertion will be analysed, and evidence to support or contradict the above claims will be examined.

Reviewing the use of shared governance

This section reports on the review of published studies which have evaluated the use of shared governance. As noted in the introduction, of 500 articles initially identified, 49 articles were subjected to assessment.

Nearly all of articles refer to systems implemented in the United States. Whilst approximately one dozen hospitals in the UK have been reported to be implementing a shared governance system, the search did not pick up any published evaluative literature other than the above three studies (Legg and Hennessy, 1996; Gulland and Payne, 1997; Leifer, 1997).

The bulk of these US studies were published in the early to mid 1990s. An interesting point made by Havens (1994) is that in 1990, most professional/reference units had not yet implemented a shared governance model, although the nursing literature suggested that this was happening. She sees this lack of earlier implementation as surprising, given the number of articles published in the mid 1980s advocating and describing such models. Porter-O'Grady (1994) claims that over 1000 US hospitals have implemented a shared governance organisation design for nursing departments over the last decade.

The reported scope of implementation of shared governance within employing organisations varies enormously, from one special care unit of 6 beds (Song et al., 1997) to hospital-wide implementation (Evan et al., 1995), and can involve only nursing staff, or can include all employees in a hospital. As previously mentioned, shared governance is a highly flexible approach which can be adapted and changed to suit the particular organisation's needs.

Of the four models discussed in Figure 1., the most commonly reported in the studies was the councillor system, reported in approximately half of the organisations analysed. The congressional model appears to be more common in earlier studies. No evaluative examples of the administrative model were found. The literature suggests the pre-planning should identify programme stakeholders (i.e. patients, staff nurses, nursing and hospital management, and other healthcare professionals - people who have invested time, money and other resources) and establish the outcomes expected from implementation of the innovation. The goals decided upon will then establish what model of organisation shared governance is relevant.

Deremo (1989) has summed the steps utilised for implementing congressional shared governance: (for other examples of structures, see also Peterson and Allen, 1986 - administrative model, 10 steps; Jenkins, 1991 - councillor model, 6 steps; Porter-O'Grady, 1994 - councillor model).

1. Develop shared governance structure
2. Define committee purposes, membership, officers and bylaws
3. Implement structure
4. Define roles, skills, and abilities needed to facilitate the shared governance process (e.g. setting an agenda, how to run a meeting, conflict management, team building, professional ethics)
5. Provide education to committee chair persons and members
6. Clarify purposes, roles and responsibilities of committees after six months of experience
7. Refine structures and roles after one year
8. Fully implement shared governance

The use of external consultants as advisers in this process, or reference to models devised in other organisations may have an influence on deciding which model is adopted by an organisation.

Evaluation

Relatively few articles describing the use of shared governance have made any attempt to evaluate its implementation. Ideally, evaluation should include both process and outcome measures (Martin, 1995). Process evaluation is needed to make certain that desired change has occurred or is progressing through implementation, and that resources are being used as planned. Outcome evaluation is needed to check that the changes that have occurred were what was expected and that resources utilised were used effectively (Martin, 1995). The goals of shared governance are broad (i.e. service, patient, outcome and professional), and it is the institutional specific goals of shared governance which should ultimately determine the foci for evaluation. A careful review of evaluation models and organisational research instruments would guide potential evaluators to develop an evaluation plan that is tailored to their organisation, and which will produce meaningful data for the stakeholders of their shared governance model. With regard to design, evaluation should ideally be longitudinal and assess characteristics of the nursing staff, use psychometrically sound instruments, and incorporate repeated measures, taken before, during and after implementation (Martin, 1995).

Very few of the articles reviewed comply with this "ideal measurements" protocol. Evaluation of shared governance in practice is difficult due to the complexity of the concept, the variety of definitions, and the fact that implementation is often occurring in conjunction with other nursing management and practice innovations, such as case management (McCloskey et al., 1994). As a result, studies to evaluate shared governance tend to yield mixed results, leave questions as to what has been evaluated, and often produce little opportunity for cross-comparison of results. Furthermore, many of the published studies lack rigour in the methods used and analysis of available data.

Several studies have taken a "snapshot" approach, by administration of a survey to ascertain staff views or opinions, or a questionnaire to gain a measure of certain factors or outcomes at a given point in time (e.g. Shidler et al., 1989; Volk and Lucas, 1991; Brodbeck, 1992; Daugherty and Hart; 1993; Finkler et al., 1994; Havens, 1994; Harris and Verdeber, 1994; Reif, 1995; Nocar-Bowen and Ford, 1995; Legg and Hennessy, 1996; George, 1997; George et al., 1997). This approach can give good indications of how the process is being received by staff. It can also give some indication of how well shared governance is working, but it is not possible to compare any changes against pre-implementation data, and information obtained in this fashion is very open to subjective or situational bias/influence. Some studies, in

addition, give comparative data of shared governance staff (experimental group) versus non-shared governance staff (control group) within the snapshot (Dennis, 1991; Daly et al., 1991; Weisman et al., 1993; Hastings, 1995).

Some of the studies have undertaken time series studies, particularly those which have taken pre- and post-implementation measures (e.g. Zelauskas and Howes, 1992; Scott and Totten, 1993; Totten and Scott, 1993; Edwards et al., 1994; Motz and Lewis, 1994; Skubak et al., 1994; Hastings and Waltz, 1995; Westrope et al., 1995; Kennerly, 1996; Laschinger and Havens, 1996; Prince, 1997; Ireson and McGillis, 1998). This methodology does allow for some comparative analysis, particularly concerning changes occurring soon after implementation of shared governance, and the longest period of repeated measurement reported was 60 months (Jenkins, 1988).

A few studies have used repeated, or longitudinal measures, but have begun measurement after implementation, so no pre-implementation or baseline measures have been given (e.g. Ludemann and Brown, 1989; Davis, 1992; Thrasher et al., 1992; Kovner et al., 1993; Minnen et al., 1993; Horstman et al, 1994; Brooks et al. 1995; Evan et al., 1995; Song et al., 1997). It is possible to gain a picture of trends in the development of the governance system from this type of study, but the absence of a baseline limits the scope for complete evaluation.

Longitudinal, repeated and ongoing measures studies are in the minority (e.g. Pinkerton et al., 1989; DeBaca et al., 1993; Jones et al., 1993; Marion et al., 1995; Pierce et al., 1996). The Jones et al. study is an example of an longitudinal evaluation study; baseline data were collected prior to implementation, shared governance was piloted on two intensive care units, then subsequently instituted throughout the nursing division. Three follow-up surveys were conducted approximately 12, 24 and 36 months post-implementation, using a range of previously tested and validated instruments on several variables to measure staff nurses' perception of shared governance. The authors issue the caveat that some changes may not be observed for 1-2 years or more post-implementation, hence the importance of long-term evaluation, as emphasised by Havens (1994) who suggests that we really need to look at a 5 year period.

One article, in the form of a case study (Hibberd et al., 1992), gave a detailed and insightful account of events prior to, during, and post implementation of shared governance, which were of significant bearing to the initial lack of success of the system, but no discussion of evaluation was offered.

Those studies not specifying the type or nature of evaluation conducted (Jones and Ortiz, 1989; Carmanica and Rosenbecker, 1991; Anderson, 1992; Gulland and Payne, 1997) are included because the implementation process is described in detail.

Outcome measures

There are various types of variables used in these studies to evaluate shared governance; in this review, they are grouped into organisational, staff, personal and financial categories. Examples of these are shown in Table 1, and are as follows:

Table 1:
Outcome measures of shared governance

Factors:	Measures:
Organisational	quality of care; patient contact; performance improvement; communication improvements; teamwork
Staff	job satisfaction; participation in decision making; absence; turnover; recruitment/retention
Personal	growth in skills/expertise; career development; job commitment
Financial	cost/benefit; cost savings (or increases)

Source: Buchan, Ball and O'May, 1998

Organisational:
An enhanced work environment, or satisfaction with the work environment was cited by several studies as a result of shared governance implementation (Scott and Totten, 1993; Kovner et al., 1993; Daugherty and Hart, 1993; Ireson and McGillis, 1998). As well as benefits to the nursing staff, benefits to the patient have also been found, such as improved quality of care (DeBaca et al., 1993, Motz and Lewis, 1994), and an increased focus on the patient (Daugherty and Hart, 1993; Ireson and McGillis, 1998), which supports the statement that the most effective measure of a shared governance

system is its effect on the quality of care given to the patient (McDonagh et al. 1989). Other benefits of shared governance implementation found include improved efficiency of services delivered (Ireson and McGillis, 1998) and a proactive monthly approach to quality assessment and improvement (Horstman et al., 1994).

One study described how a second-generation shared governance system provided structure and process support for innovative changes, which were initiated through work design (Minnen et al., 1993).

Improved communication (Brodbeck, 1992; Motz and Lewis, 1994), an increased sense of cohesiveness, teamwork and collegiality (Brodbeck, 1992; Skubak et al., 1994; Ireson and McGillis, 1998) and a spreading of shared governance into administrative ranks (Totten and Scott, 1993) and between nurses and physicians (Brodbeck, 1992) were other beneficial effects for organisations which had introduced shared governance.

Staff:
Job satisfaction is a measure much used in nursing literature and has a strong influence on many other aspects of nursing. Increased or improved satisfaction was reported in several studies (Thrasher et al., 1992; Jones et al., 1993; DeBaca et al., 1993; Motz and Lewis, 1994; Westrope et al., 1995). A major component of job satisfaction, particularly concerning shared governance, is the degree of participation extended to nursing staff. Staff who perceive an opportunity to voice issues and concerns and be genuinely involved in the making of decisions which affect their work will be more likely to express satisfaction at work.

Participation in decision making at work and prospects for promotion have been found to be linked with satisfaction (Cavanagh, 1992). Nurses who worked in a hospital with a collaborative governance programme had higher job satisfaction scores (Vilardo, 1993), and increased awareness of professionalism, autonomy, authority and accountability (Thrasher et al., 1992).

Job satisfaction may also impact on staff recruitment and retention rates, and levels of absence/sickness. Several studies of organisations where shared governance was in place reported reduced turnover and vacancy rates (Zelauskas and Howes, 1992; Brodbeck, 1992; Brooks et al., 1995; Relf, 1995; Pierce et al., 1996); reduced staff intention to leave (Jones et al., 1993) and lower sickness leave costs (Zelauskas and Howes, 1992).

Increased overall awareness of unit functioning and policies were reported by Skubak et al. (1994), and increases in positive perception of pay and promotional opportunities were reported by Zelauskas and Howes (1992).

Personal:
Alongside clinical education, self development of nursing staff is a very important component of nursing career development. Jenkins (1988) found that growth in skill, expertise and knowledge led to improved efficiency and productivity at meetings, and Totten and Scott (1993) found, following the implementation of shared governance, a tremendous opportunity for growth of individuals and expansion of experience towards future career endeavours.

Integral to the concept and growth of self-development is the nurses' sense of degree of autonomy. Nurses are reported to benefit from increased autonomy in situations of shared governance (Jones and Ortiz, 1989; Pierce et al., 1996). This was found to be the case in several studies, resulting in stronger commitment to job and organisation (Westrope et al., 1995); increased decision making (Kovner et al., 1993); increased professional growth and accountability for nursing practice (Brooks et al., 1995); and increased influence and freedom to innovate (Ludemann and Brown, 1988). Ferguson-Paré (1996) found that an increased workload demonstrated a negative relationship to nurse perception of autonomy. However Kennerly (1996) found an overall decline in nurse autonomy as the study progressed, despite a minimal increase in the first six months of shared governance implementation. McCloskey et al. (1994) comment that most reports of the effects of the shared governance model are anecdotal, focusing on effects on nurses' perceived autonomy and job satisfaction.

Financial:
Cost measures were also utilised in some studies to provide outcome data. Some studies reported no increased costs as a result of implementing shared governance, for example, no increased costs per patient day (Zelauskas and Howes, 1992). Jenkins (1988) reported that maintaining a professional governance model can be cost-neutral, with the potential to provide cost savings in the long-term. Other studies reported reduced costs directly in financial terms, e.g. where savings exceeded costs (DeBaca et al., 1993); by reduced recruitment and orientation expenses (Relf, 1995); by significantly improved productivity in hours of care per day (Finkler et al., 1995); and by lower full-time equivalent nurses (FTEs) per case in comparison with averages for the rest of the hospital (Zelauskas and Howes, 1992).

Motz and Lewis (1994) looked at budget saving, and reported that their budget figures illustrated the benefit of providing financial information and allowing staff leeway to identify and solve cost containment issues. None of the studies assessed reported increased costs, but many did not explicitly assess them.

Measurement Tools

The studies reviewed in this paper used a wide range of measurement instruments, some universally used and validated, others 'in-house', self-designed surveys and questionnaires, such as the Havens Distribution of Authority Scale (Havens, 1994). Where recognised, standardised measures are used, such as the Anticipated Turnover Scale (Hinshaw and Attwood, 1980) or the Profile of Organisational Characteristics (Likert and Likert, 1976), it is possible to make comparisons between different studies on those particular outcomes. Martin (1995) discusses concepts shown to be associated with or responsive to the development of shared governance. These include Work Satisfaction (Stamps and Piedmonte, 1986); Organisational Climate dimension of Esprit (Duxbury, Henley and Armstrong, 1982); Work Excitement (Simms, Erbin-Roesemann, Darga and Coeling, 1992), Empowerment (Laschinger and Shamian, 1994); and Work Autonomy/Nursing Acitivity (Shutzenhofer, 1983; 1987; 1988; 1994; 1997).

However, as Hess (1996) points out, one variable which is universally understudied is the independent variable, 'governance'. The author has refined and encouraged application of his Index of Professional Nursing Governance (IPNG) (1995a; 1995b; 1996; 1998), which attempts to address this deficiency, enabling quantification of change in the redistribution of governance due to the implementation of governance models. It comprises 88 questions, organised into 6 dimensions: professional control, organisational influence, organisational recognition, facilitating structures, liaison and alignment. Only one of the studies analysed in this review used the above (George et al., 1997), although many studies measured several of the dimensions in Hess' index, but utilising different tools.

Potential Barriers to Success

As can be seen from the above discussion of findings from the studies reviewed, claims for the benefits of shared governance would seem for the most part to have a valid basis, with over 90 per cent claiming some level of positive result or success.

Publication bias has to be taken into consideration. Successful implementations are far more likely to be published than those which have foundered. However, as with other innovations, successful implementation is dependent on a number of features, such as careful planning, effective communication, consistency with organisational values, and clear evaluation of results (Bernreuter, 1993). Whilst the initial decision to adopt shared governance may be an executive one, successful implementation is usually determined at the staff level (Pinkerton et al., 1989). In many organisations, it will be several years before the majority of nursing and midwifery staff have served on the various councils/committees, so a proactive approach may be needed to encourage all staff to recognise the role and significance of shared governance councils in terms of innovation in clinical practice and involvement in decision making (Mitchell et al., 1998). It is vital that staff understand what shared governance can do for them, and what procedures they must go through in order to achieve their objectives and implement change. Training is therefore essential, and examples of nurse-led innovations should be provided within such training.

1. The Management perspective:

A move from a traditional hierarchical approach to a more participative style of management can be a difficult one to adopt successfully. Inherent within such a change can be a perceived or real "loss of power" whereby managers no longer take the lead role (Geoghegan and Farrington, 1995; Wilson, 1989; Kovner et al., 1993), and have to recognise their interdependence on the teams of which they are members (Gardner and Cummings, 1994). For some administrators, this change can be seen as threatening (Schaffner and Bouman, 1992) or analogous to anarchy (Blouin and Tonges, 1996).

The process of change itself can be an uncomfortable one to contemplate, let alone implement. Managers may not like to think that the way in which they have operated in the past may be blocking participative management - problems are identified in terms of "people" and not "process" (Gardner and Cummings, 1994).

Communication mechanisms may have to be reassessed or altered, ensuring there is a systematic, formal process for involving all participants in the shared governance system (Evan et al., 1995) and no perceived lack of visibility of

'people in positions of power' (Harris and Verdeber, 1994), particularly as communication within a shared governance organisation may be cumbersome (Schaffner and Bouman, 1992).

Frequent changing of executive staff, or changes occurring at crucial stages in the implementation, can pose a threat (Hibberd et al, 1992). In this Canadian example, the shared governance project was thrown into jeopardy by the resignation of the chief nursing executive position a year after implementation.

2. The Staff perspective:

Some authors argue that nurses are socially and educationally conditioned to accept hierarchical authority and structure, and that the motivation to participate in shared governance systems can be low, certainly at the outset (Daugherty and Hart, 1993; McDonagh et al., 1989). Timeliness of implementation and readiness of staff for change (Legg and Hennessy, 1996) are factors which merit careful consideration and incorporation into the planning process. There may be initial reluctance to accept increased responsibility (resulting from increased autonomy), until such time as knowledge and skills in decision making are expanded (Geoghegan and Farrington, 1995; McDonagh et al., 1989). It is important therefore that there is concomitant training, staff support and mentorship throughout, and beyond, shared governance implementation. Shidler et al. (1989) found that an overlap of responsibilities created tensions and instability, which temporarily reduced the confidence of the new movement, and both nursing staff and managers experienced difficulties in identifying with the new roles.

Problems may arise in determining how decision-making occurs, and there is a need to ensure that ideas and concerns are directed to the appropriate council (Pinkerton et al., 1989). The group environment in decision-making renders the process slower and more cumbersome (McDonagh et al., 1989; Pinkerton et al., 1989; Daly et al., 1991), and patience and flexibility are vital attributes, while adjustments to improve efficiency are tried and tested.

Organisational and financial constraints can have a negative impact on the successful implementation of shared governance. It can be difficult for staff to find time to participate in committee/council meetings (Caramanica and Rosenbecker, 1992) and in addition, to reconcile the increased time required to sustain quality patient care as a result of involvement in new management tasks (Reif, 1995). Staff members not involved in councils or committees may resent their additional workloads, while their peers are 'in conference' (Schaffner and Bouman, 1992). In a study by George (1997), 90 per cent of the subjects surveyed believed the organisation should compensate nurses for time spent in governance activities, and in a study by Edwards et al. (1994), nurses were provided with built-in paid time to fulfil council responsibilities. However, owing to financial restraints, this monetary boost looked unlikely to continue, yet staff interviewed were committed to shared governance as "the way of life", highlighting the import of the system on their professional nursing practice.

Freeing staff nurses from patient care areas to participate in shared governance meetings can be costly when salaries for participants and staff nurse replacements are considered (McDonagh et al., 1989; Motz and Lewis, 1994). Whilst shared governance systems have been highly successful in empowering nurses for professional practice, they have been less uniform in their effectiveness for solving day-to-day operational problems (Perley and Raab, 1994).

Major financial cutbacks, which are becoming more and more common in health care, can have a potentially negative impact on innovative programmes such as shared governance. In a study by Hibberd et al. (1992), the imposition of severe financial restraints resulted in significant layoffs amongst management and staff nurses. This in itself was a severe set-back and resulted in illegal strikes, but when combined with a lack of systematic planning, and a large number and diversity of major changes concurrently introduced, and without sufficient support systems to sustain organisational change, was almost sufficient to wreck the shared governance system in place.

Accepting and knowing boundaries is another potential problem, particularly in the initial stages of implementation. Within a unit-based shared governance situation, nurses may feel frustration when decisions lie outside the realm of their own health care unit (Motz and Lewis, 1994). Occasionally, staff nurses may try to make decisions outside their realm of experience, and differentiation between management and clinical governance decisions is an area of concern that needs ongoing attention. Another factor is that shared governance could be dominated by a small group within an institution (Schaffner and Bouman, 1992), limiting the scope for general acceptance.

The Way Forward

Rose and Reynolds (1995) suggested that shared governance was the answer to retention, nursing shortages, advancing the nursing profession and expanding nurses' autonomy for their practice and work life. From the examples and literature studied, it would appear that in some reported cases, shared governance can claim positive results for some, and in a few cases, all of the above. In other cases, claimed benefits have not been identified in evaluation. Hess (1994b) offers a cautionary example where shared governance was not shown to have any relationship with past or present nurse vacancy or turnover rates, and decentralization or leadership; additionally, the shared governance hospitals were less likely to have adopted or implemented other related organisational innovations, such as quality improvement, case management or nursing information systems. The limited sample size and constituency is acknowledged.

Whilst adaptation, and manipulation of shared governance models is necessary, it is also important to acquire and use the insights of those who have already been through the process. In the true spirit of sharing, some institutions which have successfully undertaken governance are helping others implement and develop shared governance systems (Anderson, 1992). Effective communication links are vital from the outset, to provide a forum for explicitly addressing issues of trust, to foster peer support and to ensure that the vision of shared governance filters throughout the division (Davis, 1992). As Fagan (1991) stated in her study of implementation of a unit-based shared governance system, "it is impossible to communicate too much, especially when introducing a new method of doing things". A system which is implemented, without adequate introduction and explanation for all those who will be using it, will have overtones of top-down management, and from the outset, will threaten the very democratic tenets shared governance seeks to promote.

The importance of participation cannot be overlooked, but it is also very important to ensure that the participation in question is significant, and not token, in content (Allen et al., 1988). As Campbell (1991) puts it, "There is no way to dance around the issue of true shared governance. All attempts to increase staff comfort and involvement will be for naught if the nurse executive is not willing to truly share the governance of the system ..." Participative management merely allows staff to give input, after which the management will still make the decisions - shared governance is claimed to be a dimension beyond that, whereby ownership of practice decisions resides with the staff (McMahon, 1992), and where information flows freely, in all directions (Allen et al., 1988). In a US national survey (Havens, 1992), it was found that department of nursing involvement in hospital governance occurred primarily through the activities of Chief Nursing Executive, but that future projections suggested that both staff RNs and CNEs will be more involved in governing health care organisations.

Education is the key to empowering nurses and through this education, the key to empowering the people nurses serve (Clay, 1992). The reason for empowering nurses is fundamentally because by doing so, the belief is that this will improve the care of all people. Therefore, continuing education has to be emphasised and supported within the organisation once shared governance has been implemented. The principles of shared governance should become a core component of the nursing curriculum, so future nursing personnel can see local operational organisations as examplars. Care should also be taken to ensure professional nurses are prepared for their changing role, and focus placed on the education and socialisation needed to act effectively in the evolving political organisational arena.

It is evident from the review of literature that shared governance is not a panacea, a stand-alone, one-dose fix, which will inherently cure all the issues it has been employed to address. It cannot operate in a vacuum, but requires continual support, adjustment and evaluation. Shared governance may start out as an organisational process, but it needs to include people and procedures, if it is to make the transition to a continuously effective mechanism for all participants.

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